skin bridges are an uncommon complication of circumcision. It often results from either inadequate lysis of natural adhesions prior to circumcision or from distal migration of the skin from a prominent suprapubic fat pad. The majority of adhesions should cure spontaneously as the penis grows, suprapubic fat recedes, and erections become more frequent and firmer. Lysis of preputial adhesions also can be performed by gently pushing away the adhesions from the glands of penis. During healing process, the circumferential incision can adhere to the glands and in some cases heal into an epithelialized skin bridge. If thin and transparent, they can be divided in OPD manner. In our case, extensive and thick adhesions require surgical intervention, and excellent outcome was achieved.

NDP103:
INTRAURETHRAL BUDDING – CAUSED BY INCIDENTAL SEEDING ASSOCIATED WITH STONE OBSTRUCTION OF BLADDER OUTLET

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Purpose: Plants in urethra was hard to see, and there was no case report in human until now. We showed an special case about this.
Materials and Methods: This report is to present a rare case with intraurethral budding. A 56 year-old male voided one budding about 3cm in length from the urethra, accompanied with one dark-brown colored stone with 1.1 cm in size at one day.
Results: The most possible way was retrograde implant the plant seed into the urethra initially and ureteral stone blocked the urinary outlet when it passed into the bladder from the ureter which lead to the subsequent budding and growth of seed in the urethra.
Conclusion: We present an unusual case of impacted bladder stone accompanied with urethral plant seeding incidentally, and it was also the first case been reported in human.

NDP104:
SINGLE PORT LAPAROSCOPY DIAGNOSIS & RESECTION OF APPENDICOVESICAL FISTULA – A CASE REPORT

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Purpose: Appendicovesical fistula (AVF) is a rare cause of urinary tract infection. It has been reported that it usually took at least 1 year from the onset of symptom to confirmatory diagnosis. We report a case of recurrent urinary tract infection with delayed diagnosis of Appendicovesical fistula and was treated with single port laparoscopic appendectomy.
Case report: A 85-year-old male patient is a case of pancreatic tail mass s/p distal partial pancreatectomy with splenectomy and spine surgery in July, 2015 with and urinary retention and Foley indwelling since then. He had repeat hospital admission for urinary tract infection in recent 20 years and has suffered from fecaluria via Foley catheter for more than 7 months. Low GI series cystoscopy showed non-specific findings. Computed tomography (CT) of the abdomen and pelvis revealed vesico-colonic fistula in Sep, 2015. He was referred to our hospital for surgical intervention. We performed single port laparoscopic transabdomen approach for diagnosis. Pelvis appendix with tip adesion to bladder dome and pelvis side wall was visualized. We carried out appendectomy with Endo-GIA (ECR-45G) and excision of fistula between bladder and appendix. No more recurrent UTI occurred postoperatively.
Conclusion: Appendicovesical fistula is difficult in early diagnosis for patient with intractable recurrent urinary tract infection. Diagnosis and surgical intervention by single pole laparoscopy is feasible.

NDP105:
A TESTIS BURSTED OUT – A RARE SCROTAL TRAUMA WITH EXPOSED TESTICULAR DISLOCATION CASE REPORT AND LITERATURE REVIEW

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Purpose: Traumatic testicular dislocation is rare, especially with testis protruding out of the scrotum. Most dislocations occurred with other major trauma. Herein we report a case of bursted testicular dislocation without any other injury.
Case report: A 18-year-old man hit on a pillar during riding a motorcycle. His chief complaint was mild left scrotal pain. Vital sign was stable at emergency department. No wound, ecchymosis, contusion, or bone fracture was found (except some blood on underpants). Left testis was exposed out of the scrotum (pic1). Emergent scrotal repair was performed under spinal anesthesia. During the operation, we found bursted scrotal skin wound about 2 centimeter in length, and the tunica vaginalis of the exposed testis was intact. Post-operative ultrasonography showed intact testicles with normal blood flow and no hematoma nor hydrocele was noted.
Results: According to the literature we can query currently, most traumatic testicular dislocations are related to direct external impact, often accompanying with severe pelvic or systemic trauma. There were very few cases of only testicles bursting out of scrotum. This patient was wearing tight jeans, so presumably it was caused by strong shearing force which produced by powerful impact and increased frictional force provided by the tight jeans. Such blunt trauma in limited space produced impact that made the testicle protrude out of the scrotum. This kind of traumatic bursted testicular dislocation is extremely rare, so we hereby report.
Conclusion: Traumatic protruding dislocation of the testis without major trauma is rare. Emergent scrotal repair is a feasible method for patients with traumatic testicular dislocation.

NDP106:
CASE REPORT: ANTICOAGULANT AGENT INDUCE ISCHEMIC TYPE PRIAPISM

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Purpose: Priapism is a rare disease defined as pathological penile erection without sexual desire or stimulation. It may lead to urologic emergency if this situation persist more than 4 hours. Irreversible damage could happen in the cavernous tissue resulting in impotence if there is no timely and proper treatment. There are several etiology may cause the priapism. Now we report a rare case of priapism caused by low molecular weight heparin (LMWH) therapy and warfarin.
Case report: A 67-year-old male suffered from left thigh swelling with pain for 3 days. Blood examination for D-dimer showed more than 5000 ng/mL. Left thigh deep vein thrombosis (DVT) was diagnosed. Enoxaparin, one of LMWH 60mg twice daily plus Warfarin 5mg daily were prescribed for DVT treatment during hospitalization. On the third day of treatment, urologist was consulted due to painful prolong erection of penis for 2 days. Corpus cavernosum irrigation were performed under general anesthesia. We used two 18G niddle for irrigation and aspiration separately with one inserted on the proximal side of corpus cavernosum connected with normal saline for irrigation and the other inserted on the top of glans for aspiration.(picture A) However, small amount of blood was aspired so the tunica vaginalis was cut for exposed the corpus cavernosum. Dark red cavernosal tissue with minimal blood ooze was noted.(picture A) After discuss with the patient, due to the old age, penile prosthesis